

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-032652

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8324

FILED AUG 31 1962

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

St. Louis

Length of stay in 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE **Illinois** b. COUNTY **Cass**

c. CITY
OR
TOWN

Ashland

Inside Limits

Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

Missouri Baptist Hospital

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)

Reside on Farm

Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First

Melvin

Middle

Clyde

Last

Lewis Sr.

4. DATE
OF
DEATH

Month

August

Day

25

Year

1962

5. SEX

Male

6. COLOR OR RACE

White

7. Married ☒ Never Married ☐

Widowed ☐ Divorced ☐

8. DATE OF BIRTH

8/2/1902

9. AGE (last birthday)

60

IF UNDER 1 YEAR

Months

Days

Hours

Min.

IF UNDER 24 HR

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

18. CAUSE OF DEATH (Enter only one cause per line if
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Acute Peritonitis

INTERVAL BETWEEN
ONSET AND DEATH

1 wk

Conditions, if any,
which gave rise to
above cause (a),
stating the under-
lying cause last.

DUE TO (b)

Perforated Gastric Ulcer

DUE TO (c)

5401

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal
disease condition given in PART I (a)

PART III. If deceased was female was
there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY
PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

SUICIDE

HOMICIDE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF
INJURY

Hour
a.m.
p.m.

Month, Day, Year

20d. INJURY OCCURRED
WHILE AT WORK ☐
NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home,
farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from

8/17/62 to *8/25/62*

and last saw him alive on *8/25/62*

Death occurred at

7:30 am on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

[Signature] (Degree or title) *M.D.*

22b. ADDRESS

4919 Forest Park

22c. DATE SIGNED

8/27/62

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Removal

23b. DATE

8-29-62

23c. NAME OF CEMETERY OR CREMATORY

Homer Memorial Cemetery

23d. LOCATION (City, town, or county)

Champaign Co., Ill.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Gainer Funeral Home, Ashland, Ill.

25. DATE RECD. BY LOCAL REG.

AUG 27 1962

26. REGISTRAR'S SIGNATURE

Earl Smith, M.D.

USE BLACK INK

OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

John J. Harris

Licensed Embalmer No. 4108

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.